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Note by the Secretary-General

The Secretary-General hereby transmits a report prepared by the Director-General of the World Health Organization on partnerships for global health, pursuant to General Assembly resolution 68/98.

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Report of the Director-General of the World Health Organization on partnerships for global health

Summary

The General Assembly, in its resolution 68/98, called for enhanced partnerships to improve health for all, considering health in a holistic manner, with a multisectoral approach guided by the principles of national ownership, focus on results and effectiveness, transparency, shared responsibility, mutual accountability, inclusiveness and sustainability.

During the past two decades, considerable changes have taken place in the global health architecture. The present report focuses on partnerships in global public health that are helping to advance the collectively agreed health priorities aimed at obtaining better health outcomes and to ensure universal health coverage. This global health agenda is shaped primarily by the Twelfth General Programme of Work of the World Health Organization (WHO), adopted by the World Health Assembly, especially the six leadership priorities contained within it and agreed upon by all WHO Member States, as well as by the health-related goals, targets and indicators being discussed as part of the post-2015 sustainable development goals compact.

Future partnerships efforts in the health arena should be aligned with these main strategic thrusts of global health action and should identify effective means to contribute to their advancement. Well-coordinated multi-stakeholder partnerships can play a fundamental role through the support they can lend to the attainment of collectively agreed public health priorities that contribute to better health outcomes. They should constitute platforms to advance the global, regional and country health agendas, add value and have a clear purpose and scope.

However, the coordination of these streams, in connection with the global health agenda, poses significant challenges for global health governance.

I. Introduction

1. The General Assembly, in its resolution 68/98, reiterated that health is an important, cross-cutting policy issue on the international agenda, as it is a precondition for and an outcome and indicator of all three dimensions of sustainable development. The Assembly also recognized that global health challenges require concerted and sustained efforts, and that partnerships with a broad range of actors — including national Governments, local authorities, international institutions, business, civil society organizations, foundations, philanthropists, social impact investors, scientists, academics and individuals — play an important role in development.

2. In the same resolution, the General Assembly also encouraged Member States to strengthen and improve the quality of health systems. In addition, it called for the promotion of partnerships to support Member States in accelerating the transition towards universal health coverage and the achievement of the Millennium Development Goals. In particular, it drew attention to the commitments made in the initiative of the Secretary-General: to save 4.6 million children and mothers; to tackle non-communicable diseases; to enhance access to medicines and vaccines; and to act on economic, social and environmental determinants.

3. The General Assembly also requested the Secretary-General, in close collaboration with the Director-General of the World Health Organization (WHO), to submit to the Assembly, at its sixty-ninth session, a report on partnerships for global health that assesses and addresses global health governance and the interlinkages between health and all determinants, including social, economic and environmental determinants, and presents recommendations for action to be taken by relevant stakeholders to achieve improved global health governance, taking into account, in particular, human rights, good governance, mutual respect, equity, sustainability, solidarity, shared responsibilities of the international community and a people-centred approach.

4. The present report briefly addresses the protection of health workers as a way to promote public health and strengthen health systems. This is to support discussions on the forthcoming General Assembly resolution on global health and foreign policy.

II. Current role of partnerships in global public health

5. Forging new global partnerships is one of the five significant transformative shifts necessary to drive the post-2015 agenda as a universal framework for future development, according to the report entitled "A new global partnership: eradicate poverty and transform economies through sustainable development", prepared by the Secretary-General's High-level Panel of Eminent Persons on the Post-2015 Development Agenda.

6. Partnerships encompass a broad range of actors, including national Governments, local authorities, international institutions, business, civil society organizations, foundations, philanthropists and social impact investors, scientists and academics, and individuals. The principles on which these partnerships should be based include national ownership, focus on results and effectiveness, transparency,

shared responsibility, mutual accountability, inclusiveness and sustainability. Partnerships may have an expression at the global, regional or country level.

7. Partnerships may adopt different organizational modalities: from functional coordination mechanisms, to effective coalitions with multiple stakeholders, to new structural entities with their own governance and membership. Partnering does not necessary imply the need for a separate structure. To the contrary, informal collaborative alliances have proved to be useful in many cases. However, in some situations a more structural arrangement is required for better coordination. Creating an effective platform to foster the collaboration of the relevant partners is most important. Platforms for policy dialogue are sometimes extremely useful; at other times, the collaboration may require joint planning or joint operations.

8. The objective of relevant and meaningful partnerships in global public health should be to support Member States efforts in the following areas:

- To attain better health outcomes
- To develop sustainable and comprehensive health systems, promoting equity, fostering innovation to meet current and future health needs, and promoting health through the course of life
- To accelerate the transition towards universal health coverage, including access to quality preventive and curative health services, medicines, the promotion of primary health care, and avoiding financial hardship, with a special emphasis on the poor, vulnerable and marginalized
- To adopt a health-in-all-policies approach, acting on economic, social and environmental determinants in the final push towards the achievement of the Millennium Development Goals as well as paving the way towards the post-2015 development agenda
- To support research and development with respect to pharmaceuticals, diagnostics, vaccines, medical services, medical devices and other health-related technology and innovation
- To promote capacity-building in the national regulation of pharmaceuticals and commodities, quality control and supply chain management, and national and regional production
- To foster North-South, South-South and triangular cooperation, including the transfer of technologies
- To prepare for and respond to emergencies and disasters and minimize their impact on public health.

9. Multi-stakeholder partnerships have made significant contributions to the global health agenda by advancing global health priorities, maximizing outreach and advocacy, and informing policymaking. Shared public health objectives can be better met by acting in partnership than by acting alone. Partnerships have been particularly successful in raising the profile of certain critical public health issues on policy agendas through their communication efforts. Partnerships have strengthened advocacy efforts by harnessing the contribution of a diverse range of stakeholders and focusing attention on specific issues central to the mandate of the partnership. They have also provided broader platforms that facilitate the participation and engagement of a variety of stakeholders, including Governments, intergovernmental

organizations, non-governmental organizations, civil society and the private sector. Furthermore, they have successfully mobilized funding commitments to public health initiatives and have galvanized indirect forms of support for WHO programmes. Partnerships that have financing and procurement of medicines and diagnostics as their main areas of focus have been very effective in increasing access to such products for the communities that need them. Through public-private initiatives, health partnerships have been a catalyst for product innovation and have promoted accountability for resources and results. Partnerships have also played a critical role in the management of health information and knowledge-brokering. In this regard, they have generated opportunities that have contributed to the success of many initiatives set out in the WHO Twelfth General Programme of Work, as well as in the resolutions of the United Nations General Assembly.

10. WHO has the responsibility, defined in its Constitution, of being the "directing and coordinating authority on international health work". WHO manages a network of over 800 collaborating centres, participates in numerous multi-stakeholder and multisectoral health partnerships, and itself hosts seven partnerships, as well as hosting official relations with almost 200 non-governmental organizations (NGOs) and working relations with many more. As part of the WHO reform, the importance of strengthening partnerships and widening the engagement of multiple stakeholders has been recognized, and discussions among member States on principles and practical rules for engagement with these new actors are under way.

11. The policy on WHO engagement with global health partnerships and hosting arrangements, endorsed in 2010 by the Sixty-third World Health Assembly (see resolution WHA63.10, annex), emphasizes the importance of ensuring that the overall mandate of a WHO-hosted partnership is consistent with the constitutional mandate and principles of WHO. Moreover, the policy states that the activities of the partnership should be in alignment and be synergistic with the WHO technical norms and policies.

12. The above-mentioned partnerships policy listed 10 criteria for assessing WHO engagement in future partnerships and guiding its relationship with existing ones: (a) the partnership should demonstrate clear added value for public health; (b) the partnership should have a clear goal that concerns a priority area of work for WHO; (c) the partnership should be guided by the technical norms and standards established by WHO; (d) the partnership should support national development objectives; (e) the partnership should ensure appropriate and adequate participation of stakeholders; (f) the roles of partners should be clear; (g) the transaction costs related to a partnership must be evaluated, along with the potential benefits and risks; (h) the pursuit of the public health goal should take precedence over the special interests of the participants in the partnership; (i) the structure of the partnership should correspond to the proposed functions; and (j) the partnership should have an independent external evaluation and/or self-monitoring mechanism.

III. Addressing major health challenges through partnerships

13. The global health agenda is shaped primarily by the Twelfth General Programme of Work of WHO, adopted by the World Health Assembly, in particular the six leadership priorities set out in it and agreed upon by all WHO member

States, as well as by the health-related goals, targets and indicators being discussed as part of the post-2015 sustainable development goals compact.

A. Six leadership priorities identified in the WHO Twelfth General Programme of Work

14. The WHO Twelfth General Programme of Work provides a six-year high-level strategic vision for the work of WHO. It analyses the changing political, economic and institutional context in which WHO is working, outlines how these changes have an impact on people's health and countries' health systems, examines the implications of this analysis for the work of WHO, and shows the link between changing context and the programmatic, governance and management elements of WHO reform.

15. The Twelfth General Programme of Work sets out leadership priorities that define the key areas in which WHO seeks to exert its influence in the world of global health. These leadership priorities reflect the programmatic and priority-setting components of WHO reform.

16. In early 2012, WHO member States agreed upon the following criteria to be used in setting priorities for the period to be covered by the Twelfth General Programme of Work:

- The current health situation, including demographic and epidemiological trends and changes, and urgent, emerging and neglected health issues, taking into account the burden of disease at the global, regional and country levels
- Needs of individual countries for WHO support as articulated, where available through the country cooperation strategy, as well as national health and development plans
- Internationally agreed instruments that involve or have an impact on health, such as declarations and agreements, as well as resolutions, decisions and other documents adopted by the WHO governing bodies at the global and regional levels
- The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology to improve health
- The comparative advantages of WHO, including:
  - The capacity to develop evidence in response to current and emerging issues
  - The ability to contribute to capacity building
  - The capacity to respond to changing needs on the basis of an ongoing assessment of performance
  - The potential to work with other sectors, organizations and stakeholders to have a significant impact on health.

17. These priority-setting criteria were used to arrive at the six leadership priorities outlined below. They link to the Organization's role in health governance, highlighting areas in which WHO advocacy and technical leadership in the global health arena are most needed. These are the areas in which WHO will seek to shape

the global debate, to secure country involvement, and to drive the way the Organization works.

18. The six leadership priorities are the following:

- **Advancing universal health coverage:** enabling countries to sustain or expand access to essential health services and financial protection, and promoting universal health coverage as a unifying concept in global health
- **Health-related Millennium Development Goals:** addressing unfinished and future challenges: accelerating the achievement of the current health-related Goals up to and beyond 2015. This priority includes completing the eradication of polio and selected neglected tropical diseases
- **Addressing the challenge of non-communicable diseases** and mental health, violence and injuries and disabilities
- **Implementing the provisions of the International Health Regulations (2005):** ensuring that all countries can meet the capacity requirements specified in the Regulations
- **Increasing access to essential, high-quality and affordable medical products** (medicines, vaccines, diagnostics and other health technologies)
- **Addressing the social, economic and environmental determinants of health** as a means to promote better health outcomes and reduce health inequities within and between countries.

B. Health goals and targets being considered in the post-2015 development agenda discussions

19. The Open Working Group of the General Assembly, charged with the task of developing global sustainable development goals, has proposed a health goal entitled "Ensure healthy lives and promote well-being for all at all ages". Several subtargets are listed as part of this goal:

- By 2030, reduce the global maternal mortality ratio to fewer than 70 per 100,000 live births
- By 2030, end preventable deaths of newborns and children under the age of 5 years
- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases
- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol
- By 2020, reduce by half global deaths and injuries from road traffic accidents

- By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and integrate reproductive health into national strategies and programmes
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- Strengthen implementation of the Framework Convention on Tobacco Control in all countries, as appropriate
- Support the research and development of vaccines and medicines for communicable and non-communicable diseases that affect primarily developing countries; provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and Public Health, adopted at the Ministerial Conference of the World Trade Organization (WTO) in 2001, in which the WTO Members affirmed the right of developing countries to use to the full the provisions in the TRIPS agreement regarding flexibilities to protect public health; and, in particular, provide access to medicines for all
- Increase substantially health financing and the recruitment, development and training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- Strengthen the capacity of all countries, particularly the developing countries, for early warning, risk reduction and management of national and global health risks.

20. Several other proposed goals also contain targets related to health. These include, among others:

- The elimination of violence against women and children
- Universal access to sexual and reproductive health and reproductive rights
- Universal and equitable access to safe and affordable drinking water
- Access to adequate and equitable sanitation and hygiene for all and an end to open defecation
- Enhanced international cooperation to facilitate access to clean energy research and technologies, including renewable energy, energy efficiency and advanced and cleaner fossil fuel technologies; and investment in energy infrastructure and clean energy technologies
- Access to safe, affordable, accessible and sustainable transport systems for all, and improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons

- Universal access to safe, inclusive and accessible green and public spaces, particularly for women and children, older persons and persons with disabilities
- Significant reduction in the number of deaths and the number of affected people, and a reduction of y per cent of economic losses relative to gross domestic product, caused by disasters
- Environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significant reduction in their release to air, water and soil to minimize their adverse impacts on human health and the environment
- End abuse, exploitation, trafficking and all forms of violence and torture against children
- Legal identity for all, including birth registration
- Nationally appropriate social protection systems and measures for all, including floors, and substantial coverage of the poor and the vulnerable
- End all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.

21. These goals and specific targets will be the fundamental framework of collectively agreed priorities in health that will be part of the universal post-2015 sustainable development goals compact. The new imperatives of the post-2015 agenda will require a move from an approach centred on support for developing countries to one that is universal in nature, wherein collective action is pertinent to the spectrum of needs of all Member States. Partnerships will play a major role in this if they are aligned and organized with these collectively agreed priorities.

IV. Best practices in connection with partnerships around the six leadership priorities of the WHO Twelfth General Programme of Work and the post-2015 health-related goals and targets

22. Some of the examples of best practices, whether through partnerships, initiatives, coalitions or high-level political commitments, are set out below:

(a) Advancing universal health coverage

23. **International Health Partnership.** The Partnership is committed to improving the health of citizens in developing countries and achieving results by mobilizing national Governments, development agencies, civil society and others to support a single, country-led national health strategy. Partners work together to put into practice international principles for development cooperation in the health sector. The Partnership is open to all Governments, development agencies and civil society organizations involved in improving health that are willing to adhere to the commitments set out in the International Health Partnership Global Compact for achieving the health-related Millennium Development Goals.

24. **Social Health Protection Network.** Around 100 million people are pushed into poverty each year while paying for health care out of pocket during times of need. The Network seeks to respond to this global challenge. The main thrust of the Network's efforts is coherent. enhanced support for the creation and extension of sustainable health and social protection systems for universal health coverage and social health protection, based on values of universality and equity. Members of the Network include WHO, the World Bank, the International Labour Organization (ILO), the African Development Bank, France, Germany, the United States Agency for International Development (USAID), Switzerland, Spain and others.

25. **European Union-Luxembourg-WHO Universal Health Coverage Partnership.** This collaborative agreement among the European Union, Luxembourg and WHO aims to build country capacities for the development, negotiation, implementation, monitoring and evaluation of robust and comprehensive national health policies, strategies and plans, with a view to promoting universal health coverage, people-centred primary care, and health in all policies. The current programme covers the period 2012-2015 and focuses on strengthening country processes, as well as, where appropriate, aid effectiveness in line with the principles of the International Health Partnership. By building synergies, the overall objective is to improve health sector results in concerned countries, including Burkina Faso, Cabo Verde, Chad, the Democratic Republic of the Congo, Guinea, Liberia, Mali, Mozambique, the Niger, the Republic of Moldova, Senegal, Sierra Leone, South Sudan, the Sudan, Timor-Leste, Togo, Tunisia, Viet Nam and Yemen.

26. **Monitoring progress towards universal health coverage at the country and global levels: framework measures and targets.** In May 2014, WHO and the World Bank released a proposed framework for tracking country and global progress towards universal health coverage, with the aim of informing and guiding discussions on and the assessment of both aggregate and equitable coverage of essential health services as well as financial protection. Monitoring progress towards these two components of universal health coverage will be complementary and critical to achieving desirable health outcome goals, such as ending preventable deaths and promoting healthy life expectancy, as well as reducing poverty and protecting household incomes.

27. **Social Protection Inter-Agency Cooperation Board.** The Board is an inter-agency coordination mechanism composed of representatives of international organizations and bilateral institutions, the aim of which is to enhance global coordination and advocacy on social protection issues and to coordinate international cooperation in country demand-driven actions.

28. **Global Health Workforce Alliance.** The Alliance is a WHO-hosted partnership established in 2006 as a common platform for action to address the chronic shortage of health workers. The shortage of doctors, nurses and midwives is currently one of the major obstacles to achieving the Millennium Development Goals and other international health goals, including universal health coverage. Health workers are also critical to the preparedness for and response to the global security threats posed by emerging and epidemic-prone diseases. The Alliance is a partnership of over 400 organizations, including national Governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating effective and practical solutions. The Alliance engages its partners across the multiple dimensions of human resources for

health — whether in the health, education, finance or labour sector. This approach has contributed significantly to a range of initiatives and achievements at the global, regional and national levels that have enabled and will continue to enable a multisectoral focus on human resources for health within the global health agenda.

29. **Alliance for Health Policy and Systems Research.** The Alliance is a WHO-hosted partnership established in 1999 with the overall goal of promoting the generation and use of health policy and systems research as a means to improve health and health systems in developing countries. The Alliance is interdisciplinary, blending economics, sociology, anthropology, political science, public health and epidemiology together to draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape — and be shaped by — health systems and the broader determinants of health. This partnership contributes directly to the development of sustainable health systems that work to ensure universal access to quality health services and the transition towards universal health coverage. The Alliance has over 360 partners across the globe, including members from research institutions, universities, national and local governments, multilateral and bilateral agencies, international organizations, NGOs, foundations and others. These members actively participate in Alliance consultations and workshops, giving them a strong voice in the Alliance's programming and strategic decisions.

(b) Addressing unfinished challenges in connection with the health-related Millennium Development Goals

30. **High-level Task Force on Global Food Security.** The Task Force was established by the Secretary-General to address the global food price crisis through coordinated action across the United Nations system. The Task Force is now addressing more widely global food security and leading advocacy and action to implement the Secretary-General's Zero Hunger Initiative. WHO, together with UNICEF and the World Food Programme (WFP), coordinates the working group on zero stunting and collaborates on developing relevant policy guidance.

31. **Scale Up Nutrition Movement.** Scale Up Nutrition brings together representatives from 54 developing countries, donors, United Nations entities, civil society and business, organized in separate networks, to develop comprehensive multisectoral action in nutrition and related results frameworks and increase investments. The Movement has mobilized considerable political commitment, facilitated multi-stakeholder coordination and leveraged new financial resources.

32. **World Breastfeeding Week.** On the occasion of the World Breastfeeding Week in August 2014, WHO launched a network, in collaboration with the United Nations Children's Fund (UNICEF) and several civil society organizations, to strengthen the monitoring of the International Code of Marketing Breast-milk Substitutes.[1] It focuses on strengthening health services and the promotion of the Baby-Friendly Hospital Initiative,[2] as well as the implementation of the ILO Maternity Protection Convention, 2000 (No. 183),[3] and the International Code of Marketing of Breast-milk Substitutes.

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[1] See www.who.int/nutrition/publications/infantfeeding/9241541601/en/.

[2] See www.who.int/nutrition/topics/bfhi/en/.

[3] See www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312328.

33. **Secretary-General's Global Strategy for Women's and Children's Health.** Launched in 2010, the Strategy has galvanized global attention and generated some $40 billion in pledges. WHO worked closely with Governments and partners to support the strategy, and hosted the Commission on Information and Accountability for Women's and Children's Health. WHO also supported other major technical components of this work, such as the work of the United Nations Commission on Life-saving Commodities for Women and Children. Global action plans endorsed by the World Health Assembly, such as the Global Vaccine Action Plan, as well as regional action plans, also helped to translate political commitment into specific technical strategies and road maps.

34. **Partnership for Maternal, Newborn and Child Health.** The Partnership was launched in 2005 to mobilize partners and Governments to accelerate global action to improve reproductive, maternal, newborn and child health. The Partnership joins the reproductive, maternal, newborn and child health communities into an alliance of more than 600 members across seven constituencies: academic, research and teaching institutions; donors and foundations; health-care professionals; multilateral agencies; NGOs; partner countries; and the private sector. The Partnership supports countries to achieve Millennium Development Goals 4 and 5, specifically, and to progress towards the other Goals, by enhancing partners' interactions and the application of their comparative advantages to: raise resources for reproductive, maternal, child, newborn and adolescent health; promote evidence-based high-impact interventions and a means to deliver them; and track partners' commitments and measurement of progress. The Partnership is governed by a 25-member Board and administered by a secretariat hosted at WHO. The Partnership is not an independent entity, but a collaborative mechanism among its members.

35. **Roll Back Malaria Partnership.** Launched in 1998 by WHO, UNICEF, the United Nations Development Programme (UNDP) and the World Bank to ensure coordinated action against malaria, the Partnership is composed of more than 500 partners, including malaria-endemic countries, donors and multilateral development organizations, product development partnerships, NGOs, research and academic organizations and the private sector. The main objective of the secretariat is to convene global malaria partners and to facilitate collaboration, policy coordination and communication among partners. The Board brings together member States and representatives of each Roll Back Malaria constituency. WHO has a dual role: it provides technical guidance on global policy to all partners, and it has a permanent representation on the Board.

36. **Stop Tuberculosis Partnership.** Established in 2000, the Partnership serves as the main platform to facilitate, catalyse and coordinate the work of over 1,000 partners, including tuberculosis-endemic countries, donors and multilateral development organizations, product development partnerships, NGOs, research and academic organizations and the private sector. The Partnership is governed by a Coordinating Board, supported by two standing committees: the Executive Committee and the Finance Committee. WHO has a dual role: it provides technical guidance on global policy to all partners, and it has a permanent representation on the Coordinating Board. As of January 2015, the Partnership was to be hosted by the United Nations Office for Project Services.

37. **Global Polio Eradication Initiative.** The Initiative is led by national Governments, in partnership with the four spearheading partners: WHO, Rotary

International, the United States Centres for Disease Control and Prevention and UNICEF.[4] Through the Initiative, the global incidence of polio has been reduced by more than 99.9 per cent; more than 10 billion doses of oral polio vaccine have been administered to more than 2.5 billion children worldwide. The programme's size and scope have required collaboration and cooperation across countries and institutions and between the public and private sectors. The impact of the Initiative extends beyond polio, benefiting other global and country health priorities. The Initiative's infrastructure can provide a strong platform for addressing other vaccine-preventable diseases and support national health systems.

38. **Global Alliance for Vaccines and Immunization (GAVI).** The GAVI Alliance is a private-public partnership established in 2002 with the aim of addressing global inequities in access to and coverage of available lifesaving vaccines. Its mission to save children's lives and protect people's health by increasing access to immunization in poor countries is achieved through four strategic goals: (a) supporting countries' decision-making processes regarding the introduction of underused and new vaccines; (b) helping to strengthen the capacity of health systems; (c) ensuring sustainable financing; and (d) shaping vaccine markets to the benefit of developing countries. By 2013, the GAVI Alliance, with the support of its members, including donor countries, recipient countries, industry, civil society, technical institutions, unaffiliated members and United Nations agencies, had contributed to the prevention of more than 5 million future deaths due to vaccine-preventable diseases.

39. **Global Fund for Fighting Aids, Tuberculosis and Malaria.** Established in 2002, the Global Fund mobilizes, manages and disburses substantial new resources through a public-private partnership aimed at contributing to the reduction of prevalence of infection, illness and death caused by HIV/AIDS, tuberculosis and malaria in countries in need, thereby contributing to poverty reduction as part of the Millennium Development Goals. The Global Fund 2012-2016 Strategy: Investing for Impact establishes goals aimed at saving 10 million lives and preventing 140 million to 189 million new infections during the period 2012-2016 by providing funding for key lifesaving interventions, including antiretroviral therapy for HIV, treatment for tuberculosis and long-lasting insecticidal bed nets to prevent malaria. To improve the response to country's needs, the Global Fund adopted policies, strategies aimed at strengthening support for national priorities, health systems and plans for greater impact on the three diseases, promoting gender equality, attention to minorities and other vulnerable populations such as ethnic, migrant and mobile populations. In 2012, the Fund changed its funding model, moving from a project-based funding approach to a new more streamlined funding model better aligned with national strategic plans. The international Board of the Global Fund includes donor and recipient Governments, NGOs, the private sector, affected communities and United Nation organizations.

(c) Addressing the challenges of non-communicable diseases

40. In September 2011, Heads of State and Government adopted the Political Declaration of the High-level Meeting of the General Assembly on the Prevention

[4] Other partners include: the Bill and Melinda Gates Foundation, private foundations, development banks, donor governments, the European Commission, humanitarian and non-governmental organizations, corporate partners and volunteers in developing countries.

and Control of Non-communicable Diseases (General Assembly resolution 66/2, annex) and committed themselves to promote, establish or support and strengthen multisectoral national policies and plans for the prevention and control of non-communicable diseases (ibid., para. 45). Although not a partnership in itself, the Declaration prompted a broad range of activities, within United Nations agencies and with the broader community, in accomplishing a number of global assignments that would accelerate national efforts. The WHO Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020 put in place a global agenda based on nine concrete global targets for 2025. The plan was endorsed by the World Health Assembly in May 2013 (resolution WHA66.10) and comprises a set of actions that, when performed collectively by member States, international partners and WHO, will help to attain a global target of a 25 per cent reduction in premature mortality from non-communicable diseases by 2025 and achieve the commitments made by Heads of State and Government in September 2011.

41. The United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, which the Secretary-General established in June 2013 (see Economic and Social Council resolution 2013/12) and placed under the leadership of WHO, is coordinating the activities of the relevant United Nations organizations and other intergovernmental organizations to support the realization of the commitments made in 2011 by Heads of State and Government in the Political Declaration on Non-communicable Diseases, in particular through the implementation of the WHO Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020. The terms of reference of the Task Force were adopted by the Economic and Social Council in June 2014 (see resolution 2014/10).

42. Terms of reference for the establishment of the WHO Global Coordination Mechanism on the Prevention and Control of Non-communicable Diseases were endorsed by the World Health Assembly in May 2014.[5] The scope and purpose of the Mechanism are to facilitate and enhance the coordination of activities, multi-stakeholder engagement and action across sectors in order to contribute to the implementation of the WHO Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013-2020. The Mechanism is led by member States. Other participants include United Nations organizations and other intergovernmental organizations, as well as non-State actors.[6]

43. There are a number of partnerships and initiatives in support of the WHO Framework Convention on Tobacco Control and of tobacco control in general. In partnership with the Bill and Melinda Gates Foundation, the Bloomberg Philanthropies,[7] the United States Centres for Disease Control,[8] the John Hopkins Bloomberg School of Public Health[9] and two NGOs, The Union[10] and the Campaign for Tobacco Free Kids,[11] WHO is supporting countries in their efforts to

[5] See document A67/14 Add.1.

[6] In accordance with paragraph 5 of document A67/14 Add.1.

[7] See www.bloomberg.org/.

[8] www.cdc.gov.

[9] See www.jhsph.edu/.

[10] See www.theunion.org/.

[11] See www.tobaccofreekids.org/.

implement key demand reduction measures for tobacco.[12] Bloomberg Philanthropies has committed more than $600 million since 2007 to combat tobacco use worldwide and support developing countries. In 2011, WHO established the Centre for Tobacco Control in Africa in Uganda to provide technical assistance on tobacco control policies, programmes and legislation to six neighbouring developing countries.

44. The United Nations Road Safety Collaboration, led by WHO and the United Nations regional commissions, is an informal consultative mechanism whose goal is to facilitate international cooperation and to strengthen global and regional coordination among United Nations system agencies and other international partners to implement General Assembly resolutions on improving global road safety and the recommendations of the *World Report on Road Traffic Injury Prevention*,[13] thereby supporting country programmes to implement the objectives of the Decade of Action for Road Safety 2011-2020. The Collaboration holds biannual meetings to coordinate the road safety activities implemented by its 81 partner organizations, which include United Nations organizations, Member States, NGOs, foundations and academic institutions, and the private sector.

45. The Global Campaign for Violence Prevention aims to implement the recommendations of the *World Report on Violence and Health*[14] by raising awareness about the problem of violence, highlighting the crucial role that public health can play in addressing its causes and consequences, and fostering prevention. It also seeks to ensure a coordinated international response. In support of these aims, the Campaign provides a platform for the dissemination and exchange of science-based knowledge about violence prevention, and the sharing of violence prevention policies, plans and experiences. Among the key mechanisms through which the Campaign seeks to achieve its aims is the Violence Prevention Alliance. The Alliance is a network of WHO member States, international agencies and civil society organizations working to prevent violence. Alliance participants share an evidence-based public health approach that targets the risk factors leading to violence and promotes multisectoral cooperation. Participants are committed to implement the recommendations of the *World Report on Violence and Health*.

(d) Enhancing the emergency health response and implementing the provisions of the International Health Regulations

46. **Global Health Cluster.** As part of the humanitarian reform and under the aegis of the Inter-Agency Standing Committee, WHO has worked together with more than 30 partners since 2006 to expand and strengthen global capacity for effective humanitarian health action. This includes increasing the number of partners, advocating more health actors in humanitarian settings, developing complementary surge mechanisms, performing joint analysis and planning to address gaps in health service coverage in emergency settings, developing and implementing common tools and guidance, and strengthening mechanisms of individual partners to provide technical support for country programmes. The main partners include the International Medical Corps, Save the Children UK, the International Federation of Red Cross and Red Crescent Societies (IFRC), World Vision, UNICEF, the International Organization for Migration, the Office of the

[12] See www.who.int/fctc/en/.

[13] WHO, *World Report on Road Traffic Injury Prevention*, Geneva, 2004.

[14] WHO, *World Report on Violence and Health*, Geneva, 2002.

United Nations High Commissioner for Refugees (UNHCR), the European Commission Humanitarian Aid Office, the Department for International Development of the United Kingdom and USAID. The Cluster is governed by a core group composed of a limited number of partners on a rotational basis. The core group meets quarterly, while the Cluster meets in plenary twice per year.

47. **Country health clusters.** When national capacities are overwhelmed in times of natural or man-made emergencies, international partners come together to help coordinate emergency response in the health sector and to provide health services in a timely, predictable and effective manner in support of member States. The main international partners differ depending on the country situation, but always include ministry of health, local civil society and national non-governmental agencies as well as international non-governmental agencies. The cluster approach is based on consensus and collaboration; the cluster is convened by the cluster lead agency, which in most cases is WHO; subnational cluster coordination is sometimes led by partner agencies. Health clusters are part of a larger constellation of sectoral "clusters" that are guided in country by the Humanitarian Coordinator and the humanitarian country team.

48. **Foreign Medical Teams Initiative.** WHO works together with partners to establish and uphold a predictable, minimum standard for the quality of health care during emergency response, and to develop measures to ensure that member States are prepared to receive foreign medical teams and to integrate their services into the national emergency response. The main partners are IFRC, the International Committee of the Red Cross (ICRC), the International Medical Corps, the International Rescue Committee, Save the Children, various academic institutions, Australia, Spain, Switzerland, the United Kingdom and the United States. The governance of the Initiative is an advisory group under the leadership of WHO.

49. **Attacks on Health Care Initiative.** ICRC, the World Medical Association, the International Council of Nurses and WHO work together to raise awareness of the scale and nature of attacks on health care, affirm the principles of the sanctity of health care and the right to health, call for action by member States to prevent attacks, monitor the continuity of services, build alternative ways to deliver care in such settings, promote respect for health care, reaffirm the commitment to document the problem, propose solutions and advocate the protection of health workers and facilities. The initiative is under the co-leadership of ICRC and WHO, which jointly convene and collaborate on related issues. Within this initiative, WHO has been tasked, pursuant to World Health Assembly resolution 65.20, with developing a methodology for collecting relevant data; an inter-agency task team led by WHO was established to finalize this methodology.

50. **Stand-by agreements to provide technical assistance to Member States in emergencies.** Pre-established agreements for NGO deployments of qualified emergency experts to WHO response operations have resulted in 26 deployments to emergency settings since these partnerships began in mid-2013. WHO has signed stand-by agreements with the Information Management and Mine Action Programme (iMMAP), Red-R Australia, the Norwegian Refugee Council and Canada's Civilian Reserve (CANADEM), and is in negotiations with additional groups. The Department for International Development is a main funding partner of the stand-by agreements. These WHO partnerships are part of a larger partnership called the Stand-By Partnerships Partners, composed of 24 United Nations and NGO

partners, including large agencies such as UNICEF, the United Nations Educational, Scientific and Cultural Organization, UNHCR and WFP. The secretariat of the Stand-by Partnerships Partners is run by the Office for the Coordination of Humanitarian Affairs. The partnership meets twice per year.

51. **Thematic Platform for Health of the International Strategy for Disaster Risk Reduction.** This partnership gathers actors from governmental, private, non-governmental, civil society, academic and research institutions and community organizations whose activities help to improve health outcomes for people at risk of emergencies and disasters. Its role is to advocate, share information and catalyse action on emergency and disaster risk management for health, and to implement the Hyogo Framework for Action through health and other sectors. The main partners are the United Nations Secretariat for International Strategy for Disaster Risk Reduction, UNICEF, Public Health England, CBM and IFRC. WHO convenes the thematic platform; its decisions are made through consensus; it meets face to face on the margins of the meetings of the Global Platform for Disaster Risk Reduction.

(e) Increasing access to affordable medical products

52. Established in 2006, UNITAID is an innovative financing initiative that seeks to increase access to medicines in developing countries by boosting the availability of affordable medicines, diagnostics and related commodities for HIV/AIDS, tuberculosis and malaria. The distinctiveness of UNITAID comes from its unique funding model, based on an air ticket levy and long-term contributions from Governments to secure steady, reliable and sizeable funding. The Board is composed of representatives of member States, civil society networks and foundations. WHO is one of the UNITAID implementing partners, together with UNICEF, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Population Services International, the Clinton Health Access Initiative, the Global Partnership to Stop Tuberculosis and several other organizations.

53. **Global Action Plan for Influenza Vaccines.** The Global Action Plan is a comprehensive WHO strategy and collaboration to reduce the current global shortage of influenza vaccines for seasonal epidemics and pandemic influenza in all countries of the world through three major approaches: (a) increase the use of seasonal vaccines; (b) increase vaccine production capacity; and (b) carry out research and development. With respect to increasing global vaccine production capacity, 14 developing country partners have been awarded grants to establish in-country manufacturing capacity for influenza vaccine: Brazil, China, Egypt, India, Indonesia, Iran (Islamic Republic of), Kazakhstan, Mexico, the Republic of Korea, Romania, Serbia, South Africa, Thailand and Viet Nam. Seasonal influenza vaccine production capacity increased from fewer than 500 million doses per year in 2006 to close to 1 billion doses per year at the end of 2010. The overall goal of the Global Action Plan is to have sufficient global influenza vaccine manufacturing capacity by 2015 to immunize 2 billion people, and the vaccine should be available on the market six months after the transfer of the vaccine prototype strain to vaccine manufacturers.

54. **Global strategy and plan of action on public health, innovation and intellectual property.** This initiative aims to promote new thinking on innovation and access to medicines and provide a medium-term framework for securing enhanced and sustainable needs-driven essential health research and development

relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area as well as facilitating access to affordable medical products. The strategy and action plan encourage needs-driven research rather than purely market-driven research and cover the use and dissemination of research and development knowledge, as well as leveraging funds for health research and development. Partners and stakeholders include WHO member States, NGOs, the pharmaceutical industry, academia, civil society organizations, the World Intellectual Property Organization (WIPO), WTO, the United Nations Conference on Trade and Development, the United Nations Industrial Development Organization and WHO.

55. **WHO, WIPO and WTO trilateral cooperation on public health, intellectual property and trade.** WHO, WIPO and WTO are strengthening their cooperation, partnership and practical coordination on issues related to public health, intellectual property and trade. The three organizations meet regularly, exchange information on their respective work programmes and discuss and plan common activities within the possibilities of their respective mandates and budgets. The trilateral cooperation is intended to help to enhance the empirical and factual information basis for policymakers and support them in addressing public health in relation to intellectual property and trade.

(f) Addressing the social, economic and environment determinants of health

56. **United Nations platform on social determinants of health.** Following the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, from 19 to 21 October 2011, ILO, the United Nations Joint Programme on HIV/AIDS (UNAIDS), UNDP, the United Nations Population Fund (UNFPA), UNICEF and WHO have agreed to work together on the social determinants of health to reduce health inequities and promote development, supporting countries in implementing the Rio Political Declaration on Social Determinants of Health. The secretariat of WHO coordinated a meeting in March 2012 to draw up an output-oriented two-year plan for work with ILO, UNICEF, UNDP, UNFPA and UNAIDS. Other activities of the platform include coordinating United Nations country missions to support country efforts to address the social determinants of health to improve health equity.

V. Protection of health workers

57. Health workers are at high risk of violence all over the world. Between 8 and 38 per cent of health workers suffer physical violence at some point in their careers. Many more are threatened or exposed to verbal aggression. Most violence is perpetrated by patients and visitors. Categories of health workers most at risk include nurses and other staff directly involved in patient care, emergency room staff and paramedics.

58. Violence against health workers is unacceptable. It not only has a negative impact on the psychological and physical well-being of health-care staff, but also affects their job motivation. As a consequence, this violence compromises the quality of care and places health-care provision at risk. It also leads to immense financial losses in the health sector.

59. As major emergencies around the globe increase in scale, complexity and frequency, the targeting of health workers in conflicts and other humanitarian crises continues. The ongoing trend of attacks on health-care workers, hospitals, clinics and ambulances in the Central African Republic, Iraq, South Sudan, the Syrian Arab Republic and Gaza and other areas represents a breach of the fundamental right to health.

60. Threats against and the harassment of health workers in West African countries have also been a worrying element of the Ebola virus disease outbreak. These professionals are taking personal risks to provide critical medical care, but they have been threatened, shunned and stigmatized.

61. Assaults on health workers and facilities seriously affect access to health care, depriving patients of treatment and interrupting measures to prevent and control contagious diseases. Doctors, nurses and other health workers must be allowed to carry out their lifesaving humanitarian work free of threats of violence and insecurity.

62. While the adverse impacts of attacks on health care have been well documented in conflicts such as those in South Sudan, the Syrian Arab Republic and Gaza, health workers are also being prevented from carrying out their essential work outside war zones. In Nigeria and Pakistan, polio vaccinators, most of them female, have been specifically targeted.

63. Interventions to prevent violence against health workers in non-emergency settings focus on strategies to better manage violent patients and high-risk visitors. In disaster and conflict situations, in which health workers may become the targets of collective or political violence, interventions focus on ensuring the physical security of health-care facilities. More research is needed to evaluate the effectiveness of these programmes, in particular in low-resource settings.

64. WHO, ILO, the International Council of Nurses and Public Services International jointly developed the *Framework Guidelines for Addressing Workplace Violence in the Health Sector*[15] to support the development of violence prevention policies in non-emergency settings, as well as a questionnaire and study protocol to research the magnitude and consequences of violence in such settings. For emergency settings, WHO has also developed methods to systematically collect data on attacks on health facilities, health workers and patients.

65. However, as the ongoing Ebola virus outbreak clearly shows, the protection of health workers requires the establishment of a systemic approach to the comprehensive clinical management of infectious diseases, especially life-threatening viral diseases, the procurement of appropriate medical devices, including personal protective equipment, and the building of the capacity of health workers to apply proper protocols and use current practices, including through training and skills transfer. Infection prevention and control programmes are essential in preventing so called health-care-associated infections, which can affect patients, health-care workers and visitors.

[15] International Labour Organization, International Council of Nurses, World Health Organization and Public Services International, *Framework Guidelines for Addressing Workplace Violence in the Health Sector*, Geneva, International Labour Office, 2002.

66. Protecting those who care for the sick and vulnerable in the world's most difficult circumstances is one of the most pressing responsibilities of the international community.

VI. Recommendations

67. Well-coordinated multi-stakeholder partnerships can play a fundamental role through the support they can lend to the attainment of collectively agreed public health priorities that contribute to better health outcomes. They should constitute platforms to advance the global, regional and country health agendas, add value and have a clear purpose and scope. Future partnerships efforts in the health arena should be aligned with these main strategic thrusts of global health action and should identify effective means to contribute to their advancement.

68. Future efforts of multi-stakeholder partnerships should address the following critical areas in connection with the abovementioned leadership priorities:

(a) Advancing universal health coverage:

- **Support the development of national health plans and legislation best-practices**
- **Support the design and implementation of national health financing models that increase the financial protection of the most vulnerable**
- **Support the design and implementation of health service delivery models for national health systems that increase coverage and improve the scope and quality of services**

(b) Addressing unfinished challenges in connection with the health-related Millennium Development Goals:

- **Support national efforts to increase access to key interventions for people living with HIV**
- **Support national efforts to increase the number of successfully treated tuberculosis patients**
- **Support national efforts to increase access to first-line anti-malaria treatment for confirmed malaria treatment**
- **Support national efforts to increase vaccination coverage for hard-to-reach populations and communities**
- **Support countries in their efforts to increase access to interventions for improving the health of women, newborns, children and adolescents**

(c) Addressing the challenges of noncommunicable diseases:

- **Support countries in their efforts to increase access to interventions to prevent and manage non-communicable diseases and their risk factors**
- **Support countries in their efforts to increase access to services for mental health and substance use disorders**

- **Support national efforts to reduce risk factors for violence, injuries and nutritional risk factors**
- **Support countries in their efforts to increase access to services for people with disabilities**

(d) **Implementing the provisions of the International Health Regulations:**

- **Support countries in attaining the minimum core capacities required by the International Health Regulations 2005 for all hazards, alert and response**
- **Increase the capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics**
- **Increase country capacities to manage public health risks associated with emergencies**

(e) **Increasing access to affordable medical products:**

- **Support countries in their efforts to improve access to the rational use of safe, effective and quality medicines and health technologies**
- **Strengthen national health regulatory authorities**

(f) **Addressing the social, economic and environment determinants of health:**

- **Support national efforts to increase intersectoral policy coordination to address the social, economic and environmental determinants of health**
- **Support countries in the identification and mitigation of environmental threats to health.**

69. **Despite the advances in effective development cooperation practices, recipient countries still face the challenges of duplication, fragmentation and high transaction costs in their interaction with the myriad health partnerships that have emerged during the past two decades. Further efforts are required to align the work of partnerships and partners with national health policies, strategies and plans, as well as to more clearly identify the comparative advantages of the newly created partnerships.**

70. **Effective health partnerships must ensure country ownership. They should consider the needs of countries and respond to them, recognizing that a "one-size-fits-all" approach is not appropriate. The coordination of these streams, in connection with the global health agenda, poses significant coordination challenges for effective global health governance.**